CCDF Provider Eligibility Standards Packet

Recertification Facility

IMPORTANT!!

To continue participation as a provider for the CCDF voucher program, the facility must demonstrate it is still in compliance with CCDF Provider Eligibility Standards. A verifying visit must occur within 12 months of the previous certification visit to avoid a disruption in participation.

No payment of CCDF voucher funds will be made to any program until all provider standards have been met and a visit verifying compliance has occurred.

A representative of The Consultants Consortium (TCC) will conduct a certification visit and information of compliance to the provider eligibility standards will be shared with the intake agent. Failure to complete re-certification will result in your inability to continue as a CCDF voucher provider.

**********Important**********

If, during the recertification process, TCC discovers that the facility was previously certified with documentation that does not meet the state's CCDF Provider Eligibility Standards, you will be required to submit new documentation. (For example, if the drug testing was not performed by a drug testing laboratory that meets CCDF Provider Eligibility Standards Guidelines.

REQUEST FOR CCDF PROVIDER ELIGIBILITY STANDARDS CERTIFICATION

Return this form with completed documentation to: **The Consultants Consortium (TCC)**
PO Box 1186
Indianapolis, IN 46206-1186

Business Name _____ Facility Director_____

Program Address _____

Mailing Address, if different _____

Phone Number _____ Fax Number_____ EIN_____

Email _____Day & Hours of Operation _____

The following documentation must be submitted to TCC for the director and any employees or volunteers working in the facility being certified:

- Consent for Statewide Criminal History check, Child Protection Index check, and Sex Offender Registry search submitted on State Form 53323, including any individual under the age of 18 previously waived to adult.
- Picture ID for persons required to sign State Form 53323 preferably a driver's license or State ID

Additionally, **if there has been no change in the applicant (responsible party signing this application), please submit the following documentation.**

- Caregivers/Volunteer Caregivers Worksheet, signed (Form B)
- Provider's written supervision policy for employees under age of 18, if applicable
- Emergency staffing plan
- Proof of applicant's current First Aid and annual CPR
- Proof of running water (water bill or water quality test) – PUBLIC SCHOOLS EXEMPT
- Proof of continuous phone service (past 12 months or letter from phone company) – PUBLIC SCHOOL EXEMPT
- Child Immunization Form (Immunization records must be on the enclosed form signed by the child's doctor or medical professional) – PUBLIC SCHOOL EXEMPT –DO NOT INCLUDE THESE FROMS WITH THE APPLICATION
- Annual documentation from a physician reflecting results of symptom screening for tuberculosis, if applicable

All childcare staff are required to provide relevant documentation listed above to the facility which will be verified by TCC at the time of inspection.

The following personal documentation should be submitted with this application if the applicant is not the same person as the person who signed last year, additionally, new staff must provide this to the facility.

- Results of a drug test (supplied to the verifying agency by the lab), with signed consent form
- Results of TB test, signed by a physician or nurse practitioner – original
- Supplemental Criminal History Information – Applicant, signed (Form C)
- Proof of current First Aid and annual CPR

I understand I will be visited by a representative of The Consultants Consortium (TCC). This visit will be scheduled after all required documentation is received by TCC. The verification visit will confirm compliance of the required CCDF Provider Eligibility Standards for receipt of CCDF childcare voucher dollars. If the provider eligibility standards are met with satisfaction, I will be certified by the Family and Social Service Administration as a certified CCDF childcare provider.

PROVIDER SIGNATURE _____ Date _____

SEE REVERSE SIDE OF THIS FORM FOR IMPORTANT INSPECTION INFORMATION

Internal Use Only

☐ Complete ☐ Incomplete By _____

Internal Use Only

Completion Date / By

FORM A

PES Recert Facility Packet
Revised 10-01-07

The following will be posted and/or verified by a TCC representative at the time of your home visit.

- ☐ Child Immunization Records will be reviewed
- ☐ Posted evacuation plan in case of fire or severe weather (Form 1)
- ☐ Posted monthly fire drill chart (Form 3)
- ☐ Posted emergency telephone numbers (Form 4)
- ☐ Emergency contact information for all children (Form 5)
- ☐ Working telephone
- ☐ Fire Marshall Compliance Letter – PUBLIC SCHOOL EXEMPT
- ☐ All firearms and ammunition inaccessible to children
- ☐ All medications, poisons, chemicals, bleach, cleaning materials are inaccessible to children
- ☐ Two exits on opposite sides of the house, unobstructed, that do not go through an area where hazardous materials are stored. Exits must be doors and cannot pass through a garage that contains any hazardous materials (gas, cars, mowers, etc.)

Employee/volunteer records to be verified by a representative from TCC

- ☐ Results of TB tests, signed by a physician or nurse practitioner – original
- ☐ Proof of current First Aid training
- ☐ Results of drug test
- ☐ Proof of CPR for at least one person at all times

NOTE: IF THE DRUG TEST OR CHECKS ARE MORE THAN 60 DAYS OLD AT THE DATE OF RECEIPT OF A COMPLETED PACKET, THEY WILL NOT BE ACCEPTED.

TCC will request Statewide Criminal History check, Child Protection Index search, Sex Offender Registry search on the applicant, all employees and volunteer caregivers after submission of the completed State Form 53323. An inspection will not be scheduled until the checks have been received.

A copy of ALL documentation sent to the verifying agency MUST be retained for your records. This will prevent problems and possible additional costs to you if your paperwork is lost. You should request a copy of your drug test results from the lab conducting your test.

Caregivers/Volunteer Caregivers Worksheet

Business Name _____ Facility Director (Applicant) _____

Please list all individuals who will be providing care and whose documentation will be verified by The Consultants Consortium (TCC) at the time of certification. Please attach **copies** of identification (i.e. driver license) of all individuals who will be providing care.

Printed Staff Name	Birthdate	INTERNAL USE ONLY							
		Criminal History	Child Protection Index	Sex Offender Registry	Drug Test	First Aid (all)	CPR (at least one staff)	TB Test	Supplemental Criminal History

I certify that the individuals listed above are the only persons serving as caregivers or volunteer caregivers at this location. I understand that should staffing changes take place after certification; the appropriate personal documentation will be collected and made available to the CCR&R upon request. Failure to stay in compliance with staffing documentation requirements will be considered non-compliance and could result in the inability of your organization to participate in the CCDF Provider Eligibility Standards program.

Applicant's signature _____ Date _____

Title _____

Return signed form to the verifying agency, TCC, with Form A, Request for Provider Eligibility Certification

Provider Name _____

Supplemental Criminal History Information
Director
Child Care Development Fund

I, _____, have been informed that participation in the Child Care Development Fund Voucher Program requires the following individuals to consent to a statewide criminal history check:

a. The provider (defined as the applicant for voucher payment)
b. Any employee or volunteer serving as a caregiver at the facility where the provider provides child care.

I have also been informed that in addition to the requirement to consent to a statewide criminal history check, I shall report to the verifying agency, The Consultants Consortium, any information regarding:

1. Police investigations;
2. Arrests; and
3. Criminal convictions

not listed on a the criminal history provided regarding any of the persons required to provide the criminal history listed above.

I understand by my signature that I must report this information to the verifying agency immediately and that my failure to report this information may result in my inability to participate in the Child Care Development Fund Voucher Program.

Signed, _____ Date _____

This form must be signed and returned to the verifying agency, with Form A, Request for Provider Eligibility Standards Certification.

Form C

Provider Name _____

Supplemental Criminal History Information
Employee or Volunteer
Child Care Development Fund

I, _____, have been informed that participation in the Child Care Development Fund Voucher Program requires the following individuals to consent to a statewide criminal history check:

a. The provider (defined as the applicant for voucher payment)
b. Any employee or volunteer serving as a caregiver at the facility where the provider provides child care.

I have also been informed that in addition to the requirement to consent to a statewide criminal history check, I shall report to the verifying agency, The Consultants Consortium, any information regarding:

1. Police investigations;
2. Arrests; and
3. Criminal convictions

not listed on a the criminal history provided regarding any of the persons required to provide the criminal history listed above.

I understand by my signature that I must report this information to the child care provider requesting my criminal history immediately and that my failure to report this information may result in the provider's inability to participate in the Child Care Development Fund Voucher Program.

Signed, _____ Date _____

This form must be signed and maintained by the facility.

Form C-1

"People helping people help themselves"

Mitchell E. Daniels, Jr., Governor
State of Indiana

Indiana Family and Social Services Administration
402 W. WASHINGTON STREET, P.O. BOX 7083
INDIANAPOLIS, IN 46207-7083

E. Mitchell Roob Jr., Secretary

June 3, 2005

Dear CCDF Child Care Provider,

As you may be aware, the CCDF provider standard defining supervision as "within sight and sound at all times" (470 IAC 3-18-1(23) has been voided by the Indiana General Assembly. Therefore, this letter serves to provide guidance as to what is meant by the standard of continual supervision found in Indiana Code 12-17.2-3.5-5.5. To ensure the safety of children in child care settings that accept CCDF vouchers, and for the protection of Indiana's providers, continuous supervision will be defined as follows.

- Caregivers shall supervise children by sight **or** sound at all times. Sound monitors alone shall not be considered as an acceptable means of supervision.
- Children shall remain on the same floor of the facility as the caregiver.
- During mealtimes, children shall remain in the caregiver's line of sight.
- Children shall not be left alone either inside or outside. With the written permission of parents, school age children (grade one and above) may be allowed to participate in activities outside the direct supervision of a caregiver. These activities must occur **on the premise** of the child care home. The caregiver must physically check such children every 15 minutes.
- Children who are able to toilet independently, including fastening and unfastening clothing, wiping themselves, flushing the toilet, and washing their hands, may use a bathroom for a short period of time without direct adult supervision.
- Children may sleep outside of the provider's direct line of vision as long as the following conditions are met:

    1. Children remain on the same floor of the home as the provider. Provider's children may sleep in their own beds.
    2. The doors to the rooms where children are sleeping remain open.
    3. Periodically, sleeping children shall be visually monitored and checked to insure they are breathing normally. Children under 15 months of age should be checked approximately every 15 minutes.

In addition, the agency provides the following guidance on safe sleep practices. To reduce the possibility of Sudden Infant Death Syndrome, children age 12 months or younger must be placed on their backs to sleep, unless the caregiver receives a written waiver of this requirement from a health care provider. Infants must sleep in a safe crib or port-a-crib. The following are the current safety guidelines for cribs and port-a-cribs.

- The slats of the crib can be no more than 2 3/8inches apart.
- Mattresses must fit snuggly with no more than one inch between the mattress and the side of the crib.
- The sides of the crib must be locked in the raised position while babies are sleeping.
- Never put anything soft, such as pillows, thick blankets, comforters, stuffed animals, or sheepskins in the crib with a sleeping baby. If a light blanket is used, it should be securely tucked in at the foot of the crib and reach only as far as the infant's chest.

Finally, sleeping infants should never be placed on an adult bed, sleeping bag, sofa, pillows, or thick blanket.

The safety and well being of Indiana's children are the top priority for all of us. Thank you for your hard work and dedication to this goal.

Sincerely,

E. Mitchell Roob Jr.,
Secretary
Family and Social Services Administration

cc: CCDF consultants

I have read and understand the policies set forth in this letter.

Signed, _____ Date_____

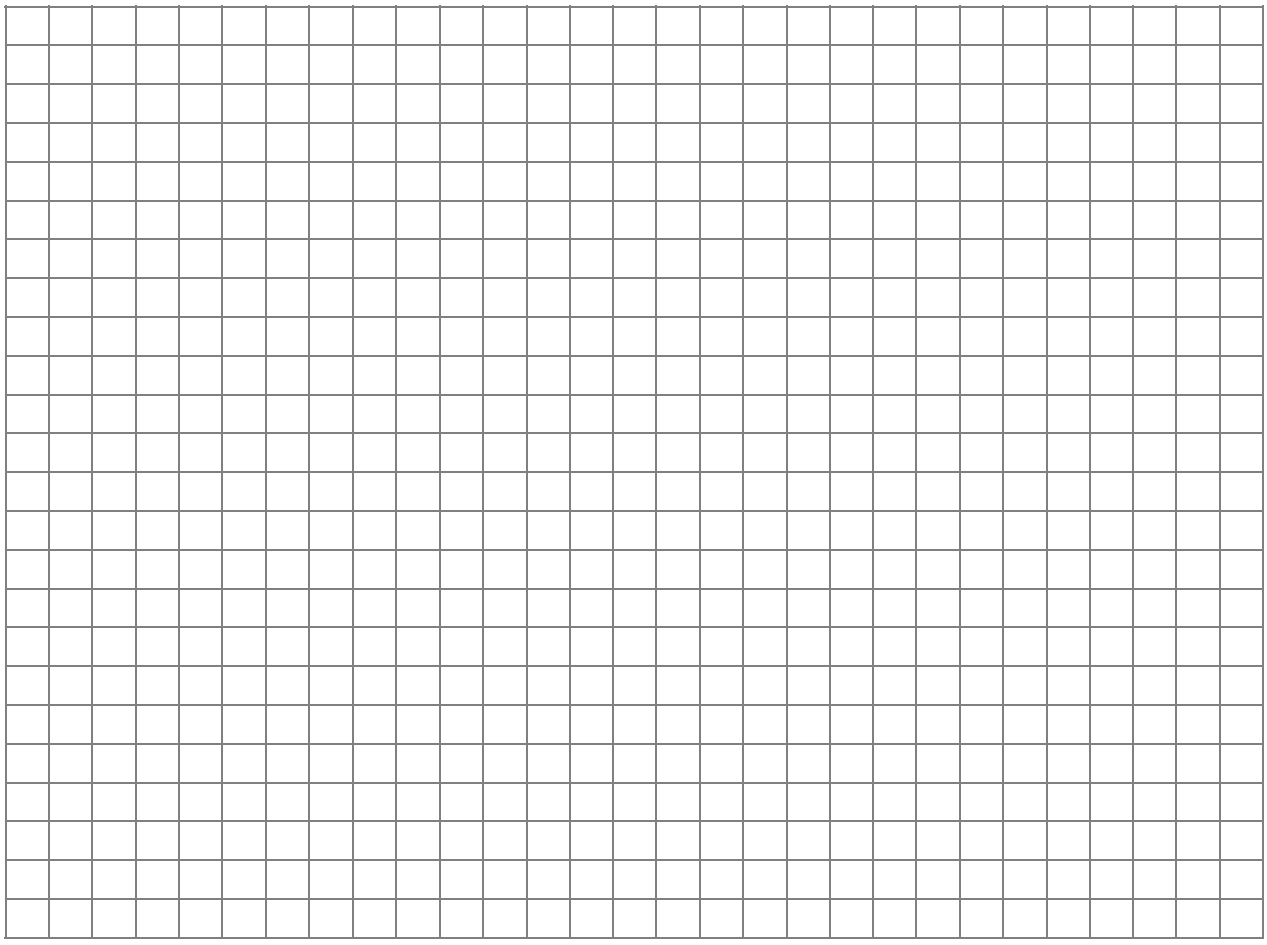
This form must be signed and returned to the verifying agency, with Form A, Request for Provider Eligibility Standards Certification

Provider Name _____ Location Address _____

Evacuation Plans
Drawn Evacuation Plan, in case of Fire or other emergency

In CASE OF FIRE

Use the graph below, and draw lines where all the walls in your home/program are. Label the rooms, and mark the doors and windows. **Find two ways out.** Use arrows to mark at least two ways out of your house. Be sure to mark ways out of every room. Choose a meeting place outside, at least 50 feet from your home/program. **This graph should reflect the route you will take during a fire drill.**



Outside meeting place: _____

Remember to practice fire drills monthly!!!

In Case of Severe Weather

If possible, with a colored marker or pen, mark the location on the graph above where you will gather in the event of a tornado or severe weather. It should be a basement or interior area, where the children will not be exposed to flying glass. If possible, store a battery operated radio and flashlight, blankets, small toys and books in this area. Take your cell or portable phone (if available) with you to this area.
Location:_____

This form or one similar to it, must be posted in your home in a visible location. You must also submit it to the verifying agency, with Form A, Request for Provider Eligibility Standards Certification.

Form 1

Monthly Fire Drill Log

Provider Signature _____

Date	Time	Weather Conditions at Time of Fire Drill	Number of Children Present	Length of Time to Evacuate	Smoke Detectors Checked & Okay	Attendance Taken at Gathering Place	Name of Person Conducting Drill

FIRE DRILLS MUST BE CONDUCTED MONTHLY AND THIS LOG AVAILABLE FOR THE VERIFYING AGENCY AT THE TIME OF RECERTIFICATION.

This form or one similar to it, must be posted and will be verified during the Provider Eligibility Recertification

Form 3

Provider Name _____

Emergency Contacts to Be Posted By the Phone

Fire _____

Ambulance _____

Poison Control 1-800-222-1222_____

Police _____

Our address is:

_____

_____

Our Phone Number is: _____

This form or one similar to it, must be posted in your home next to the telephone, and will be verified during the Provider Eligibility Standards Certification.

Provider Name _____

Emergency Contacts for Children

Child's Name_____
Address_____
Phone_____ Birthdate _____

Primary Contact_____
Employer_____ Phone_____
Cell phone _____Beeper _____

Alternate Contact_____
Employer_____ Phone_____
Cell phone _____Beeper _____

Alternate Contact_____
Employer_____ Phone_____
Cell phone _____Beeper _____

Special medical health need(s):_____
_____
_____

Parent's Signature:_____
Date:_____

This form or one similar to it will be verified during the Provider Eligibility Standards Certification

Provider Name _____

Child Immunization Record

Child's Name _____ **Date of Birth** _____

Parent's Name _____ **Phone** _____

Address _____
Street Address City State Zip

Record Date of Immunization

	1	2	3	4	5
Hep B					
DtaP / DTP / Td					
Hib					
MMR					
IPV					
Varicella					
PCV / Prevanar					

Child has documented history of varicella disease ___ No ___ Yes If yes, age ___
***Please note varicella or documented immunity (chicken pox) are required for participation in the CCDF program. PCV/Prevanar is also required when age appropriate*.**

Please check the appropriate response

- ❑ Child has received complete age-appropriate immunizations.
- ❑ Child is currently in the process of receiving complete age-appropriate immunizations.

Comments: ***(Please list immunizations excluded for medical reasons)*** _____

_____

_____

Parent comments: (Please indicate religious objection, if any)

_____

_____

Signed**,** _____Date_____
Health Care Provider's signature

Printed Name and Title _____

This form shall be updated annually

DRUG TEST MUST BE CONDUCTED BY SAMSHA CERTIFIED LABS
Child Care and Development Fund Drug Testing Guidelines
Effective October 31, 2002

Indiana Code 12-17.2-3.5-12.1 requires each childcare provider to provide drug test results which do not show a presence of illegal controlled substances for themselves, all individuals residing in the home over the age of eighteen (18) and any employee or individual caring for children on their behalf prior to participation in the Child Care and Development Fund (CCDF) program. This drug test shall test for Amphetamines, Cocaine, Opiates, PCP and THC. Each drug test shall meet the following criteria.

1. Chain of Custody shall follow guidelines, which are consistent with U.S. Department of Transportation requirements. (See specific Chain of Custody instructions listed below.)
2. Each drug screen shall be processed by a lab, which has been certified by the Substance Abuse and Mental Health Services Administration (SAMHSA, formerly NIDA).
3. Drug test results shall be reviewed by a nationally certified Medical Review Officer using positive cut-offs established by the U.S. Department of Transportation. Drug test results must include contact information for the Medical Review Officer and signature when possible.
4. Drug test results shall be faxed or mailed to the verifying agent.

The following Chain of Custody shall be followed for drug testing results provided to the Family and Social Services Administration as required by Indiana Code.

- ❑ The collector shall ask the donor for photo identification.
- ❑ After verification of donor's identification, the collector will complete step one of the custody of control form provided by the laboratory (non-regulated).
- ❑ The collector will ask the donor to remove any unnecessary outer clothing (coat, etc.) and leave hand carried items (briefcase, etc.) outside toilet enclosure. The donor may be required to empty his/her pockets at collector's discretion.
- ❑ The collector will instruct the donor to wash and dry his/her hands.
- ❑ The collector will provide the donor a wrapped and sealed collection container and/or specimen bottle. Either the collector or the donor may open the container bottles in donor's presence.
- ❑ If the container and bottle are wrapped together, the donor should be allowed to take container and bottle into toilet enclosure. If container and bottle are wrapped separately, only the collection container should be taken into toilet enclosure. The wrapped bottle should remain outside enclosure and then opened in the donor's presence when the donor gives the filled collection container to the collector.
- ❑ The collector will accompany the donor to toilet enclosure when it is time for the donor to provide urine sample. The donor will enter toilet enclosure and shut the door, the collector remains outside the closed door.
- ❑ The donor will hand filled collection container to the collector, both the donor and the collector should maintain visual contract of the specimen until labels and seals are placed over bottle caps.
- ❑ The collector checks specimen and reading of the specimen temperature indicator within four minutes of receiving the specimen from the donor. The collector then marks the appropriate box on custody of control form.
- ❑ The collector checks specimen volume ensuring there is at least thirty milliliters of urine in a single specimen collection.
- ❑ The collector checks specimen for unusual color, odor or other physical qualities that may indicate an attempt to adulterate the specimen.
- ❑ The collector will pour at least thirty milliliters into the specimen bottle.
- ❑ The collector immediately places lid/caps on specimen bottle and then applies tamper evident labels/seals.
- ❑ The collector will write the date on label field. The donor will be asked to initial labels/seals when affixed to the bottles.
- ❑ After sealing the specimen bottle, the donor will be permitted to wash and dry his/her hands, if he/she so desires.
- ❑ The donor will be instructed to read and complete the donor certification section of the custody of control form, including signing certification statement.
- ❑ The collector will complete collector's certification section of custody of control form, including signing certification statement.
- ❑ The collector will record any remarks concerning collection process in "remarks section" of custody of control form.
- ❑ The collector will complete chain of custody block of custody of control form. At a minimum, the collector will complete; the specimen, received by, purpose of, change, date, and released by blocks of the custody of control form.
- ❑ The collector will give the donor his/her copy of custody of control form and the donor may leave collection site at completion of this step of the collection process. It is not necessary for the donor to remain at collection sight while specimen bottle and custody of control form are prepared and packaged for shipment.
- ❑ The collector will prepare the bottle and copies of the custody of control from for shipment to the laboratory. The bottles and custody of control form copies will be shipped in a padded mailer or shipping container secured with an outer seal. The collector will initial and date the seal on the shipping container.
- ❑ Finally, the collector will send the MRO copy of the form directly to the MRO addressed on the form and the employer copy to the designated representative.

CCDF Substance Abuse Screening
Test Consent Form

CCDF Provider Name: _____ Phone: _____

CCDF Provider Address: _____

Individual providing sample: _____

- ❑ Provider
- ❑ Employee
- ☐ Household Member

Indiana Code 12-17.2-3.5-12.1 requires that each childcare provider shall provide drug test results which do not show a presence of illegal controlled substance(s) for themselves, all individuals residing in the home over the age of eighteen (18) and any employee or volunteer caregivers caring for children prior to participation in the Child Care and Development Fund (CCDF) program. This shall include Amphetamines, Cocaine, Opiates, PCP and THC.

I, the undersigned, have been informed that drug test results must be provided to the Division of Family Resources (DFR) and the CCDF verifying entity for participation in the CCDF program. The DFR and the verifying agency shall maintain confidentiality of these results. The results of this drug test will be used to determine eligibility for participation in the CCDF program. If drug testing results of the provider or any individual required to supply such a test, indicate the presence of an illegal controlled substance, the provider is ineligible to participate in the CCDF program. I further understand that this test and any subsequent test will be conducted at the provider's expense. An inconclusive drug test will not be considered a drug test for purposes of determining program eligibility.

Name of Verifying Agency: **The Consultants Consortium (TCC)**

Name of Contact Person: **Christy Burnley, PES Program Manager** Fax Number: **317-972-0351**

Address: **PO Box 1186, Indianapolis, IN 46206-1186** Phone Number: **317-638-7095 or 866-921-6623**

I understand that if I refuse to consent to take the test and provide the results to the DFR and the verifying agency, the verifying entity will be unable to document my compliance with CCDF Provider Eligibility Standards and thereby will be unable to authorize me, my household member's or employer's participation in the CCDF program. *I understand that I may be required to provide additional test on a random basis or when suspicion of non-compliance is documented.*

I have read and understand the Drug Testing Guidelines and consent form that have been provided to me.

I hereby: _____ Consent _____ Refuse to Consent

to the drug test; to providing the results to the DFR and the verifying agency, and to the use of the results to determine eligibility for the CCDF voucher program.

Individual receiving test: _____ Date/Time_____

Collection site representative:_____ Date/Time_____

(Please provide a copy of this signed release form with the drug test results to the agency listed above.)

CONSENT TO RELEASE INFORMATION FOR LICENSED CENTERS, LICENSED HOMES, UNLICENSED REGISTERED MINISTRIES, AND CCDF LLEPs

State Form 53323 (R / 9-07) / BCC 0330

DIVISION OF FAMILY RESOURCES / BUREAU OF CHILD CARE

The information in this document is confidential according to IC 6.1-1-35-9.

In accordance with IC 12-17.2-4-5(a)(1), IC 12-17.2-4-32(a), and IC 12-17.2-6-14(c), each staff member and/or volunteer shall complete a section of this form in order to have their background information checked.

You must return this completed form to your consultant.

Name of facility / licensee / LLEP / applicant		
Address of facility (*number and street, city, state, and ZIP code*)		
License / registration number / LLEP number	Name of consultant	County

By signing below, I hereby consent to a release of information from Child Protective Services and the Criminal Justice System to the Indiana Child Care Licensing Section, Bureau of Child Care, and to the licensee / applicant. The information may contain any prior criminal history, arrest record, or child protective service history and is sought to ensure the safety of children in child care settings. I also verify that all information given here is correct.

Name of licensee / applicant (*please print*)				Maiden or other name	
Social Security number	Date of birth (*month, day, year*)	Sex		Race	
Address (*number and street, city, state, and ZIP code*)					
Signature of licensee / applicant				Date (*month, day, year*)	
FOR OFFICE USE ONLY	CH ☐ Record found ☐ Record not found	Date (*month, day, year*)	CPI ☐ Record found ☐ Record not found	Date (*month, day, year*)	SOR ☐ Record found ☐ Record not found
					Date (*month, day, year*)

Name of licensee / staff / volunteer / household member over eighteen (18) (*please print*)				Maiden or other name	
Social Security number	Date of birth (*month, day, year*)	Sex		Race	
Address (*number and street, city, state, and ZIP code*)					
Signature of licensee / staff / volunteer / household member over eighteen (18)				Date (*month, day, year*)	
FOR OFFICE USE ONLY	CH ☐ Record found ☐ Record not found	Date (*month, day, year*)	CPI ☐ Record found ☐ Record not found	Date (*month, day, year*)	SOR ☐ Record found ☐ Record not found
					Date (*month, day, year*)

Name of licensee / staff / volunteer / household member over eighteen (18) (*please print*)				Maiden or other name	
Social Security number	Date of birth (*month, day, year*)	Sex		Race	
Address (*number and street, city, state, and ZIP code*)					
Signature of licensee / staff / volunteer / household member over eighteen (18)				Date (*month, day, year*)	
FOR OFFICE USE ONLY	CH ☐ Record found ☐ Record not found	Date (*month, day, year*)	CPI ☐ Record found ☐ Record not found	Date (*month, day, year*)	SOR ☐ Record found ☐ Record not found
					Date (*month, day, year*)

Name of licensee / staff / volunteer / household member over eighteen (18) (*please print*)				Maiden or other name	
Social Security number	Date of birth (*month, day, year*)	Sex		Race	
Address (*number and street, city, state, and ZIP code*)					
Signature of licensee / staff / volunteer / household member over eighteen (18)				Date (*month, day, year*)	
FOR OFFICE USE ONLY	CH ☐ Record found ☐ Record not found	Date (*month, day, year*)	CPI ☐ Record found ☐ Record not found	Date (*month, day, year*)	SOR ☐ Record found ☐ Record not found
					Date (*month, day, year*)

Signature of person verifying information	Date (*month, day, year*)

Subsititute Form
State Form 23743(R 07/01)
Approved by State Board of Accounts 2001
Approved by Auditor of State 2001

Taxpayer Identification Number Request

State of Indiana

W-9

DO NOT send to IRS

Print or Type

Legal Name (OWNER OF THE EIN OR SSN AS NAME APPEARS ON IRS OR SSN RECORDS)
DO NOT ENTER THE BUSINESS NAME OF A SOLE PROPRIETORSHIP ON THIS LINE

Return to address below

Trade Name Complete only if doing busines as (D/B/A)

Remit Address

Purchase Order Address- Optional

Check legal entity type and enter 9 digit taxpayer Identification Number (TIN) below:
(SSN = Social Security Number, EIN = Employer Identification Number)

SSN or EIN must be for legal name above.

- ☐ **Individual** (Individual's SSN) _ _ _ - _ _ - _ _ _ _.
- ☐ **Sole Proprietorship** (Owner's SSN or Business EIN) SSN _ _ _ - _ _ - _ _ _ _. EIN _ _ - _ _ _ _ _ _ _.
- ☐ **Partnership** ☐ General ☐ Limited (Partnership's EIN) _ _ - _ _ _ _ _ _ _.
- ☐ **Estate / Trust** (Legal Entity's EIN) _ _ - _ _ _ _ _ _ _.
  Note: Show the name and number of the legal trust, or estate, not personal representatives.
- ☐ **Other** (Limited Liablility Company, Joint Venture, Club, etc) (Entity's EIN) _ _ - _ _ _ _ _ _ _.
- ☐ **Corporation** Do you provide legal or medical services? ☐ Yes ☐ no (Corp's EIN) _ _ - _ _ _ _ _ _ _.
- ☐ **Government** (or Government operated entity) (Entity's EIN) _ _ - _ _ _ _ _ _ _.
- ☐ **Organization Exempt from Tax under Section 501(a)** (Org's EIN) _ _ - _ _ _ _ _ _ _.
  Do you provide medical services? ☐ Yes ☐ no
- ☐ Check here if you do not have a SSN or EIN but have applied for one.

Under penalties of perjury, I certify that:

(1) The number listed on this form is my correct Taxpayer Identification Number (or I am waiting for a number to be issued to me) AND

(2) I am not subject to backup withholding because: (a) I am exempt from backup witholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends or (c) the IRS has notified me that I am no longer subject to backup withholding (does not apply to real estate transactions, mortgage interest paid, and acquisition or abandonment of secured property, contribution to an individual retirement arrangement (IRA), and payments other than interest and dividends.)

CERTIFICATION INSTRUCTIONS -You must cross out item (2) above if you have been notified by the IRS that you are currently subject to backup withholding because of under reporting interest or dividends on your tax return.

THE IRS DOES NOT REQUIRE YOUR CONSENT TO ANY PROVISION OF THIS DOCUMENT OTHER THAN THE CERTIFICATIONS REQUIRED TO AVOID BACKUP WITHHOLDING.

I am a U.S. person (including a U.S. resident alien).

NAME (Print or Type) _____ TITLE _____

AUTHORIZED SIGNATURE _____ DATE _____ PHONE _____

Agency use only

Agency _____ 1099 ☐ Yes ☐ No Approved by: _____

REQUEST FOR TAXPAYER IDENTIFICATION NUMBER AND CERTIFICATION

Purpose of form: We are required to file an information return with the IRS and must get your correct taxpayer identification number (TIN) to report our payments to you.

Use Form W-9 on the reverse side, if you are a U.S. person (including a U.S. resident alien), to give us your correct TIN and, when applicable to:

1. Certify the TIN you are giving is correct.
2. Certify you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are an exempt payee.

If you do not provide us with the information, your payments may be subject to 31% federal income tax backup withholding. Also, if you do not provide us with this information, you may be subject to a $50 penalty imposed by the Internal Revenue Service per I.R.C. 6723.

Federal law on backup withholding preempts any state and local law remedies, such as any rights to a mechanic's lien. If you do not furnish a valid TIN, or if you are subject to backup withholding, the payer is required to withhold 31% of its payment to you. Backup withholding is not a failure to pay you. It is an advance tax payment. You should report all backup withholding as a credit for taxes paid on your federal income tax return.

Specific Instructions: Enter your legal name on that line. Your legal name is the one that appears on your Social Security Card or your Employer Identification Number if a business. If you are a sole proprietor, then your legal name is the business owner's name. If you have a "doing business as" (d/b/a) name, enter on the trade name line. Enter your remit address on the next line, and if you have a separate address for purchase orders enter that address on the appropriate line.

Next select the organization type for your name, check the box, and record the appropriate taxpayer identification number (TIN) in the space provided. Notice that individuals and sole proprietors are the only types with a social security number. If you are a corporation or an exempt 501(a) organization, you must answer yes or no on legal and medical services. If you are a sole proprietor you must show the business owner's name in the legal name box and the business name in the trade name box. You cannot use only the business name. For the TIN, you may use either the individual's SSN or the employer identification number (EIN) of the business. However, the IRS prefers that you show the SSN.

Finally, complete the certification section, sign and date the form.

If you are a foreign person, use the appropriate Form W-8.